

**CAPITAL PROJECTS ADVISORY REVIEW BOARD
PROJECT REVIEW COMMITTEE - PANEL**

**Northwest Carpenters Facility
25120 Pacific Highway South**

Kent, Washington

March 25, 2010

9:30 AM

Draft Minutes

MEMBERS PRESENT

Penny Koal, Vice Chair, SPSCC/Department of General Administration (GA)	Rodger Benson, MA Mortenson Company
Charles Davis, Evergreen Healthcare	Tom Balbo, Ferguson Construction, Inc.
Tom Peterson, Hoffman Construction Co. of WA	Phil Lovell, Turner Construction NW
Dave Marberg, University of Washington	Frank Abart, Whatcom County
Don Gillmore, Seattle Public Schools	Linneth Riley-Hall, City of Seattle
Mark Scoccolo, SCI Infrastructure, LLC	Peg Staeheli, SvR Design Company
Keith Schreiber, Schreiber Starling & Lane Architects	Darron Pease, Pease & Sons, Inc.
Tony Benjamin, Urban League of Metro Seattle	Paul Powell, Jr., CPO Construction

STAFF, GUESTS, PRESENTERS

Dan Chandler, Olympic Associates Company	Robyn Hofstad, Department of General Administration (GA)
Derek Rae, Olympic Associates Company	Don Wilson, Mason General Hospital
Tyler Tonkin, GLY	Valerie Gow, Puget Sound Meeting Services
Ted Herb, GLY	Eric Moll, Mason General Hospital
Nick Nye, GLY	Bob Appel, Mason General Hospital
Marc Estvold, Marc L Estvold, AIA	Lois Jean Broadway, TGB Architects
Jim Elliott, GLY	Vincent Oliver, Island Hospital
Robert Johnson, Mason General Hospital	Rob Johnson, Perkins Coie LLP
Marnie Boomer, Scherer Associates	Peter Swanson, Island Hospital
Kevin Duffy	

Welcome & Introductions

Chair Phil Lovell convened a panel of the Capital Projects Advisory Review Board (CPARB) Project Review Committee (PRC) at 9:33 a.m. Everyone present provided self-introductions.

Chair Lovell commented that the next meeting will be of the full committee on May 27. He stressed the importance of members attending because of election of officers and to receive an update on the legislative outcome by Nancy Deakins. One major change in legislation in RCW 39.10 is the ability of the GC/CM and owners to hire electrical and mechanical subcontractors in the same process as the GC/CM. The legislation is widely supported. However, that process is also optional.

Roger Benson inquired about the status of proposed legislation to eliminate boards and commissions. Chair Lovell replied that the CPARB and the PRC were slated for elimination. Early on, CPARB and PRC were removed from the elimination list.

Project Application Review for GC/CM Island Hospital, Skagit County

(Panel Chair Tom Balbo, Panel Members Tony Benjamin, Rodger Benson, Linneth Riley-Hall, Peg Staeheli, Don Gillmore, Chuck Davis, Frank Abart, and Dave Marberg)

Panel Chair Tom Balbo welcomed everyone and outlined the application review process. Panel members and guests provided self-introductions.

Peter Swanson, Chief Financial Officer, Island Hospital, introduced team members Marc Estvold, Project Manager, and Lois Broadway, Principal Architect, TGB Architects.

Mr. Swanson reported the hospital and the Board of Commissioners contributed substantially to the prior GC/CM process for the \$40 million new hospital wing which included a new nursing unit and emergency room, a new radiology/imaging department, and a new laboratory. That project helped the hospital produce the building on time and under budget. Discussions between the architect and the contractor during that project were important in achieving budget and scheduling goals.

Mr. Swanson said the proposed project has some particular issues in that the new building will be built adjacent to the new hospital building and the emergency room with a connector between the new building and the hospital to eliminate patient disruption in transporting patients to the emergency room. Early discussions with the architect and the contractor are critical to achieve that goal.

Lois Broadway reported the team didn't intend for the project to become so complex, but ultimately it ended up to be very complex because the team tested the feasibility of several different options for satisfying all hospital needs, as well as meeting the complexity of the project while complying with local codes. Initially, the team started with a conventional master plan, which was completed prior to the hiring of the project team.

Tony Benjamin arrived.

Ms. Broadway displayed an illustration of the master plan. There are a number of challenges with the proposed location of the new medical office building. It poses the maximum disruption, but also has a number of long-term benefits. Before selecting the proposal, the master plan was tested to see if four year old assumptions still applied today. The team considered another location in the center of a wide buildable area that included a large staging area. However, the connectivity to the hospital was not in the right location, as well as the proximity of locating a helistop on the roof of the building and that proximity to the emergency room, ambulance, and trauma entrance. Another location for consideration involved taking the footprint of the building and expanding it to take advantage of locating a helistop on the roof while taking advantage of other proximities. There was however, a significant grade change creating problems. It was also recognized that it was not wise land stewardship of the hospital's property to build a one-story building consuming much of the land base when the building could be multi-story.

Many factors of consideration included relocation of the existing helipad to the roof of the new building in close proximity to the Emergency Department. It allowed for increased parking at the main hospital front door and within the building, relocating the existing outpatient Cancer Care Program, adding a new dialysis program, relocating an existing outpatient physical therapy program (currently offsite), and introducing a new Hyperbaric and Wound Care facility to serve community needs as well as a pain management program. All those programs would be housed in the same building. To accomplish that most effectively, the hospital will have staff traveling between the existing hospital and the new facility. In that respect, proximity is important. Access to

the Emergency Department is important. The building will also borrow utilities from the Central Plant. By placing a helistop on the roof, new creative solutions are necessary for air handling to accommodate exhaust systems while minimizing the amount of square footage necessary for the helistop.

Ms. Broadway outlined the location of existing hospital footings. There is a subtle grade change between the existing hospital face and the foundation and the location of the new building. To that extent, matching floor levels, creating continuity and connection between the two buildings, and protecting existing footings and foundation from new facility construction activity are important and will entail auger cast piles. There is some sensitivity in disruption to patients and services as patient rooms are located in close proximity.

The team discovered that in reviewing the original assumption in the master plan, the best location of the new building is within the southeast corner of the property adjacent to the hospital. The hospital is hopeful of utilizing a GC/CM process to ensure a contractor is hired early that understands infection control issues, working within an Emergency Department as well as the entire hospital system, and understands the disruption from drawing utilities from the Central Plant to the existing building and crossing the existing Emergency Department entrance. Emergency ambulance service currently drives through the area to drop off patients. That traffic during construction will need to be diverted and in the long-term the route will require a new design because of the connection to the entrance. Working with a contractor who understands how to divert ambulance traffic and maintain the safety of the site during construction is important. It's likely ambulances will continue to use the area to drop off patients and then divert to a vacated roadway. However, it potentially puts some of the construction area, surface parking, and staging on the other side of the ambulance route, which could be challenging.

Ms. Broadway said the proposal is for a two-story building with a helistop on the roof representing 12,000 square feet per floor plate. The helistop will consume approximately 6,000 square feet on the roof area.

Highly sensitive equipment serving the Hyperbaric & Wound Care requires coordination with vendors for delivery and installation as well as working with medical gases to support both the Hyperbaric and Wound Care Programs and the Cancer Care Program.

Marc Estvold, Project Manager, said the team believes the project is very important for a GC/CM to help the team handle all the issues involving potential conflicts and other issues associated with the hospital environment. The project complies with the RCW in terms of scheduling and phasing. The hospital must maintain occupancy 24/7. The Emergency Department is the only one in a large geographic area, which must be maintained and operational at all times. The complexity of the scheduling and the phasing as well as the location of the helistop on the roof and how all those elements interact with the Emergency Department will need to be worked through well in advance of actual construction. It's important to work out the many issues well in advance to minimize operational impacts to the hospital.

Mr. Estvold said the GC/CM process was used on a previous project that was recently completed. The team understands the value of teamwork and the association of working with the contractor. Additionally, there will be coordination between the neighborhood and the city. The hospital is located within a residential area and sensitivity is important for the neighborhood and the city. That can be accomplished through the GC/CM process. There are also some unknowns because the project will entail building next to an existing hospital and footings. There are poor soil conditions that will require consideration for the best approach that may require auger cast piles, driven piles, or some other type of special foundation. It will be valuable to have the GC/CM on board early to make those decisions.

Ms. Estvold displayed an organizational chart and described the qualifications of the team. Tom Batz is the Director of Operations. The project team members are all part of the original programming meetings through final construction. One of the criteria for the architect was experience with the GC/CM process. Based on that experience, the short list included GC/CM experience as well as throughout the project team. Contracted administration and level of experience involves the same team that was involved in the prior project. Legal staff is providing support. If approved for the GC/CM process, the hospital will advertise for a contractor who is highly qualified and has extensive experience with the delivery process.

Based on the results of the last project, management plans and lines of authority work well funneling through the Project Manager and then to the design team and the contractor. As far as fiscal benefit, involving the GC/CM early is critical. One example is value engineering completed early in the process to ensure it's implemented. Currently, the project is at the early programming stage. If the GC/CM process is approved, the GC/CM will be involved in schematic design when it's still possible to make changes with the architect without incurring great expense. The process has been established based on hiring the GC/CM early.

Mr. Estvold reported the project budget includes \$265 a square foot for construction of the building or \$5.8 million. The detailed schedule includes seven months for design and permitting and 10 months for construction. The team has committed to the Board to open the new facility on January 1, 2012. Currently, the schedule tracks for an opening in October 2011, providing several months of additional time. There is continuity of the project team as the same team was involved in the prior project. The budget includes a 12% contingency. The team believes the budget is adequate for the project. The project will be funded through a 25-year non-tax revenue bond.

Mr. Estvold reported three questions were submitted by panel members. The first question involves whether the hospital will hire an independent estimating firm. Mr. Estvold confirmed that in the plan that is not a component of the architectural firm. The proposed firm of selection is Gram Sage Graves as the estimating firm. The panel asked about weighting the team will consider for evaluating the GC/CM. The team is using 40% for the RFQ, 40% for the interview, and 20% for GC/CM experience. A series of criteria will be included within each of the weightings. Mr. Estvold said the last question concerned whether the hospital is allowing for allowances in the subcontractor bid packages, and if so, the nature of the allowances and the bid packages. On the last project, the hospital allowed allowances within the subcontractor bid packages. The team will work with the GC/CM to determine what is appropriate and what the team believes are the appropriate amounts. An allowance was include for the last project for the auger cast pile package for obstructions as well as an allowance for the gypsum wall board subcontractor bid package for undocumented trade damage. He said at this point, he can't identify which packages will include an allowance.

Mr. Swanson reported the hospital incurred an audit finding on the last project for a change order. At the time, there were two concurrent projects utilizing the same contractor. Based on that experience, hospital representatives understand the situation involving that particular change order as it wasn't related to the project authorizing the GC/CM process. As this project will include the same personnel, the hospital has learned from that experience. Mark Estvold as the Project Manager obviously understands all the change orders and if there is a need for interpretation, the team will consult with the legal team. All change orders will be signed by the CEO. The team learned from that experience and is confident that it won't occur again.

Panel Chair Balbo invited questions from the panel.

Rodger Benson commented that the application packet was very complete and an outstanding application. The application was complete and responsive to the questions. He asked if any lessons were learned from the previous GC/CM project that might impact the approach to the proposed project. Mr. Estvold said the last

project was very smooth. Generally speaking, the hospital was very pleased with the process other than the change order issue. Mr. Estvold added that the team didn't totally agree with the Auditor's finding. However, the hospital has changed the process to avoid a similar situation in the future.

Don Gillmore said it appears the design time is fairly short as well as the construction timeline. He asked if there are many doctors involved in design process. Mr. Estvold said Department Directors are working with the team. Programming is approximately halfway complete. Ms. Broadway said the project will house all hospital departments, which are more specific to department heads of the hospital to provide guidance as opposed to independent physicians or physician groups.

Mr. Gillmore asked whether any concurrent construction or maintenance will occur during the project that could potentially interfere with the GC/CM process. Mr. Estvold said there is no planned activity that conflicts with the project. The hospital recently rebuilt the Central Plant. Mr. Gillmore asked if the GC/CM would be involved in any modifications to the Central Plant. Mr. Estvold affirmed that would be the plan. Ms. Broadway added that as part of the programming phase, the team has the mechanical, electrical, and engineering team on board. The team has been asked to complete a feasibility study of modifications to the Central Plant or any impacts to the Central Plant caused by the proposed project. Mr. Gillmore asked about the number of personnel working with Mr. Estvold. Mr. Estvold said he is an independent project manager.

Dave Marberg referred to the use of allowances and the prior use in terms of the value not only to the client but to the GC/CM who manages the work. He recommended providing the allowance for soil and excavation because of some of the unusual soil conditions and what may be discovered in the ground. He also recommended an overtime allowance, as premium time for overtime is one of the least cost insurances to ensure the schedule is maintained. It allows the GC/CM and the subcontractors to work on a weekend if necessary to avoid project conflicts with hospital staff while also accumulating some additional time. In the management chart the architect is in direct contract with the GC/CM. He asked whether all the architect work changes and RFIs go through the Project Manager before it goes to the GC/CM. Mr. Estvold advised that in most cases that will be the process. Mr. Marberg added that based on his experience, it's an important line so that most of the traditional responses will come from the construction manager of the project. Another experience he encountered is doing a better study on prevailing winds and air intakes for the associated buildings. He said he assumes for the new building the team has strategically located the air intake approximately 400 feet in the air. He asked if the commissioning consultant has been utilized before. Mr. Estvold said a consultant was used on the last project. The hospital has advertised for statement of qualifications from commissioning agents. The hospital will proceed through the process and hire a commissioning agent to ensure the agent is involved in the process early so that the agent's information is included within the bid documents.

Chuck Davis said one issue not addressed is the consideration the hospital factored from a fiscal standpoint for the GC/CM process over traditional Design-Bid-Build (D-B-B) because the bidding environment can be very advantageous to an organization. The last project involving his company came in at 50% of the estimate. That can have both positive and negative elements. He asked about the hospital's considerations for a traditional project. Mr. Estvold said the team considered the option especially based on the current bid market; however, with the GC/CM process, the hospital is essentially bidding the process through obtaining a bid from a GC/CM and then releasing subcontractor bids. More importantly is the life of the building. There are so many things that can occur in a project that can't be controlled. Having a contractor as part of the team in the long run is a far better value for the entire project. Mr. Davis complimented the team on the completeness of the application and the planned improvements for the community.

Peg Staeheli echoed similar comments on the completeness of the application. She asked about the responsibility for noise and traffic control for the neighborhood as well as the process for informing the

neighbors on progress of the project. Mr. Estvold said the GC/CM will take the final responsibility for street clearance and working during City allowed hours. Communication with the neighbors includes regular meetings by hospital staff based on their interest on what the hospital is doing in terms of parking and view impacts. The hospital has a good relationship and a communications process with the neighborhood. Feedback from the neighborhood is swift if the hospital is undertaking an activity that is not supported by the neighborhood.

Ms. Staeheli commented on her familiarity with hospitals and how appalled she is with the lack of ADA requirements. She asked how the team anticipates addressing that concern. She encouraged the team to consider that the project's ADA accommodations may not be sufficient. Ms. Broadway said there are several factors that will prompt the project to comply and accommodate people of disability or size. The entire building will be a hospital-licensed facility. The hospital is governed by the State Department of Health (DOH) and all documentation must be submitted to DOH for approval. That is governed by the FGI Guidelines for Design and Construction of Health Care Facilities which includes specific criteria for clearances. That is followed by whether the contractor builds to the design. If not, then the contractor is obligated to tear it out and rebuild it. The team policing the project during construction must recognize any shortfalls and point out any that are discovered. There are two places where those challenges can be perceived, met, and corrected. Ms. Staeheli commented that the industry is not doing a good job in adhering to ADA requirements especially at the hospital level.

Mr. Marberg asked if there are any in-patient areas within the new building. Mr. Estvold said there are no in-patient accommodations in the new building. Mr. Marberg referred to the floor leveling allowance and the importance of it within a hospital. Mr. Estvold said the last project utilized the entire allowance.

Chair Panel Balbo said the proposal letter said the pavilion incorporates a high degree of complexity and property ownership issues. He asked whether those issues will be solved prior to the hiring of the GC/CM. Mr. Estvold advised that the issues were recently resolved in terms of property ownership and zoning issues. Mr. Peterson said the heliport is only two stories above street level and suggested the hospital may want to allocate some funds for sound and air flow design measures as it could be an issue with the down flow from the helicopter blades near the entrance zone.

Panel Chair Balbo invited public comments.

Kevin Duffy said he is familiar with the team and recommends approval of the application.

Penny Koal, PRC member, representing the Department of General Administration, asked if the hospital is achieving any LEED certification for the project. Mr. Estvold said at this point the team is not seeking official certification but is considering the utilization of LEED principles to take advantage of those measures. However, at this point, no goal has been established.

Lynette Riley-Hall apologized for arriving late. She agreed with similar comments that the application was very thorough. She asked the team to be mindful of utilizing women and minority-owned small businesses. She asked how the team will consider the inclusion of women and minority-owned businesses within the project. Mr. Estvold said the team has encouraged the contractor to hire small businesses that were qualified to perform the work. The hospital encourages their inclusion and there is a statement in the advertisements encouraging women and minority-owned businesses to apply. However, beyond those efforts, the project is fairly technical and as people are qualified, the hospital encourages their participation. Ms. Riley-Hall encouraged the team to consider its packages and consider opportunities for structuring the packages to ensure those businesses can be successful when applying.

Dave Marberg moved, seconded by Rodger Benson, to approve the project application by Island Hospital, Skagit County, for GC/CM. Motion carried.

The meeting was recessed from 10:22 a.m. to 11:00 a.m. for a break.

Project Application Review for GC/CM Mason General Hospital

(Panel Chair Tom Peterson, Panel Members Keith Schreiber, Mark Scoccolo, Penny Koal, Phil Lovell, Darron Pease, Paul Powell, and Charles Davis)

Panel Chair Peterson welcomed everyone and outlined the application review process. Panel members and guests provided self-introductions.

Dan Chandler, Managing Principal, OAC Services, reviewed the presentation agenda and introduced the project team members Eric Moll, Chief Administrative Officer, Mason General Hospital; Rob Johnson, Attorney, Public Hospital District; Dick Prentke, Attorney, Perkins Coie (not in attendance); Derek Rae, Project Manager, OAC Services; John Scherer, Managing Principal (not in attendance), Scherer Associates; Marnie Boomer, Project Architect, Scherer Associates; Bob Appel, CEO, Mason General Hospital, and Don Wilson, Commissioner, Mason General Hospital.

Eric Moll reported he has been with Mason General Hospital for six years and has overall project responsibility. Mason General Hospital is part of Hospital District #1 of Mason County. There is a strong need for modernization. Half of the existing building was built in 1968 and the most recent expansion occurred in 1992. Patient access is very important as the community has grown and has needs. The project will meet the needs through expansion of surgical services and emergency room. The GC/CM process will have a significant public benefit through predictability of outcome in terms of budgeting, managing the risk of the project, and ensuring the project is completed by qualified contractors.

Marnie Boomer reported she will be leading the project from beginning to end. Scherer Associates has worked with Mason General Hospital since 2007 in a planning exercise and in parallel completed upgrades to the hospital's servers, internal upgrades and remodels throughout the facility, licensing of several of the adjacent outpatient clinics, and worked on the Central Plant for upgrading and efficiency improvements. The company has good sense of what's appropriate for the hospital in its current setting.

Ms. Boomer said she's worked in Seattle at larger firms and has managed larger projects as well as smaller ones. She has experience in education and housing with the last 11 years focused on healthcare facilities. During the last six years her work has focused on remodels and small additions.

The project scope includes a 20,000 square-foot addition of a surgical wing and lobby, infrastructure upgrades, expanded Emergency Department, reconfigured patient access, and renewal of finishes. Ms. Boomer reviewed an aerial diagram of the hospital and described the different areas of the hospital. The north part of the donut shape of the hospital was built in 1991 and includes the Emergency Department and inpatient rooms. The south part of the donut was built in 1968. During the planning exercise, it became apparent that on the east side of the complex, surgery was too undersized to be utilized to meet current day demands and technology. In order to expand economically, it made sense to move surgery.

Ms. Boomer described the members and experience level of the team to manage large projects. The project is well suited for the GC/CM process because of the complexity, which will involve remodeling 30,000 to 40,000 square feet with complicated phasing and coordination with staff.

Mr. Chandler reported Ms. Boomer and staff have done a great job in the initial phasing plan, but one of the first tasks of the GC/CM will be reviewing and refining the plan.

Derek Rae said the project meets four of the five criteria contained in RCW 39.10, Section 301. The project will include complex scheduling and phasing involving the entire hospital either through upgrades/facelifts or building out empty spaces that will move into the new surgical wing. Having a GC/CM at the early design stage is critical to the success of the project.

Secondly, the environment is an operating 24/7 critical access hospital that serves the Mason County community. The hospital includes a heliport and a currently overloaded Emergency Department that experiences many delays which speaks to the need for the project. Shutting down or having unforeseen problems arise by a contractor not familiar with operating hospitals is not an option.

Third, during the design phase, the GC/CM will be relied on to develop an effective phasing plan for inclusion within the construction documents as a part of the subcontractor bid package to ensure an efficient comprehensive phasing plan for best value for the hospital.

Finally, the technical work environment is also an important aspect because of the age of several of the buildings, which will include mechanical and electrical upgrades to existing infrastructure, new emergency generator, replacement of two boilers with three high efficiency boilers, and a new chiller. Those upgrades are tied to all spaces within the hospital. Having an experienced contractor that's worked in a hospital facility will be very important in terms of having the technical expertise and understanding when developing the sub-bid packages.

The project also meets the criteria in Section 302 regarding project management. OAC has managed eight GC/CM projects that have been approved since 2007. One was successfully completed and the remaining seven are in progress. The team includes members from Scherer Associates, engineers, and OAC members with experience in the GMD market, as well as the GC/CM market.

Mr. Rae referred to a question about the AIA documents and indicated the team will work with Rob Johnson and Dick Prentke to use the most appropriate GC/CM contract, which is currently the A133; the 2009 successor to the AIA 121. Perkins Coie has used the AIA 133 contractor once since it's been released and successfully utilized an AIA 121 over 20 times. The AIA 133 is a clear and concise contract that will be utilized. The team will follow the section guidelines and requirements for complete documents and bidding at 90% utilizing the experience of the general contractors selected for constructability and value analysis to ensure the hospital receives benefits. There will be appropriate contingencies at 12% and 5%.

Mr. Rae reviewed the project schedule. The hospital previously submitted the application in February anticipating a February presentation. However, with the new meeting schedule of the PRC that was delayed until the March meeting. The GC/CM selection is scheduled for April rather than in March as stated in the original schedule. The conceptual phase of the project programming is nearly completion with the team moving into the schematic phase in April. There will be approximately 11 months dedicated for design and construction documents. It is anticipated the project will be phased where the GC/CM will begin on the surgical wing opening space in the new facility followed by working in the existing facility over a period of two and half years.

Mr. Rae referred to a question on the budget for Phase 3, which was addressed with a previous submission. Funding of \$3 million covers the facelift of new lighting, ceiling tiles, and painting estimated to cost \$85 a

square foot. Some remodel/renovation work is scheduled in some departments on the ground floor programmed at \$300 a square foot, which should be an adequate budget for the project.

Eric Moll reviewed funding for the project. The Public Hospital District is experiencing a strong balance sheet with over \$33 million in cash with \$1.2 million in debt that will be defeased by 2013. The hospital has an A rating on its bonds and would likely have a higher rating of AA if the hospital was larger. There should be no issues in terms of raising debt in the public market based on the balance sheet.

Panel Chair Peterson invited panel questions.

Keith Schreiber asked whether the completion of GC/CM bid documents in February 2011 will include all phases. Phase 1 appears to be a discreet element of the project not tied in with the hospital. He asked if there was any consideration for that element as a traditional D-B-B with the remaining integrated work in the existing hospital completed through a GC/CM process. The argument of tying the project into the hospital is a little less strong on that component. There appears to be a four-month overlap between Phase 1 and Phase 2 and no overlap between Phase 2 and Phase 3. Mr. Rae said the separate wing ties into the existing hospital through access as well as utility connections. It is a surgical wing that needs direct access to the hospital. It will result in eliminating a patient room and tie in as part of the construction for the new surgical wing. The team believes it is critical for the coordination with the existing hospital as well as the proximity to tie into the existing hospital that involves a patient wing. It is critical to have a general contractor with the experience and knowledge working on the project.

Ms. Boomer added that other elements in Phase 1 impact existing space much more heavily, such as the generator plant, systems upgrade, new chillers that will fit best on the surgery addition that will serve the entire facility.

Mr. Chandler said senior leadership is interested in the process and considers what's the best value for the hospital and stakeholders given the bid market, as well as what makes the most sense. The team has scrutinized different permutations of the project. One thing the team is looking for in the GC/CM is compression of the schedule and looking at opportunities to complete as much work in the first phase as possible.

Mr. Boomer said the team is looking at folding the remodel and the facelift of the patient rooms on the west side of campus into Phase 1 as well because there is economy of scale by having the CG/CM complete the addition and also the remodel. The entire west side of the building will be sequentially occurring in parallel with the exterior addition. The east side of the building will include the installation of the new generator and electrical upgrades. The general contractor during Phase I will be involved throughout the entire building during all phases.

Mr. Roe said as part of the new wing, a new lobby is planned. Incorporating that element into the hospital will be critical as well.

Darron Pease said it appears the only team member with GC/CM experience is Mr. Chandler. He questioned his involvement in the project. Mr. Chandler advised that he will be involved in the project, particularly in procurement. Mr. Rae has a tremendous amount of experience in negotiated delivery. The team's brand of GC/CM that's been developed will be mirrored as close to the private sector. Mr. Rae is very experienced in that arena. Having the contractor on board, accountable, and helping the team contribute will be important. Mr. Chandler said he will assist Mr. Rae in interpreting statutes and specifics of subcontractor bonding, prequalification, subcontractor buyout, and the hearings. Sometimes there are very good contractors who haven't work as a GC/CM. The hospital tries not to preclude those contractors. People who are very good in

this delivery method sometimes need to be coached. Mr. Chandler said that will be his role to ensure the process is followed.

Mr. Pease asked whether Mr. Chandler has reviewed new legislation for selecting mechanical and electrical subcontractors. Mr. Chandler questioned the effective date of the new legislation. Mr. Lovell said he assumes it will be implemented no later than July 1. Mr. Chandler advised that it is something the team will consider. The hospital is expecting the GC/CM to mitigate risk and obtaining the best deal in today's market as well as navigating the subcontractor market.

Mr. Lovell asked whether the team has considered utilizing the new MEP GC/CM procurement delivery process and particularly whether the team is addressing or planning to address hazmat issues. Ms. Boomer pointed out the location of the main mechanical room and the main chillers located with the generator. The facilities were built in 1968. Mr. Lovell commented that the team could run into asbestos, rotten piping, or space problems. Mr. Chandler said the hospital is having a full site study completed. A plan for abatement will be developed based on the findings from the study/audit. Ms. Boomer said for the new high efficiency boilers, the plan is to use existing space. The generator will move to a separate building. The chiller is currently located on the roof with the plan to install two new chillers on the new building and use the existing chiller as a backup.

Mr. Lovell said he's not totally clear about the timing in terms of the occupied hospital and new space/programs. Ms. Boomer described some specifics pertaining to the phasing schedule and movement and impacts to services and programs as the remodel and expansion occurs. Mr. Rae added that the hiring of the GC/CM now is critical in coordinating all the elements of the phased project.

Penny Koal said another benefit of the GC/CM is value analysis. She asked how that element will be incorporated within the schedule. Mr. Rae said value analysis will be during the schematic stage where 80% of the savings can be identified. The initial value analysis will be completed at the schematic phase and that the tool will be revisited during all phases of the project.

Charles Davis commended the hospital and administration for taking on the work to address the needs of the community. He questioned whether any financial analysis was completed between GC/CM and traditional delivery methods especially in today's competitive market. He asked why the hospital elected to utilize the GC/CM process. Mr. Chandler said 90% of the project will be hard bid regardless of the process. The hospital is paying something for the risk mitigation and planning and the hospital believes there will be return on investment in many areas. A phased modernization of a hospital is one of the riskier jobs to assume. Risk mitigation is worth the GC/CM. If the hospital bids the project, it's possible to tightly schedule phasing, but not without taking on some extreme risks.

Mr. Appel added that the hospital has developed its 10-year strategic plan, which has helped put the hospital in a beneficial financial position to complete the modernization project. As part of that financial plan, a facility master plan was developed on improvements desired for the hospital. That plan was developed several years ago when the market was different. The hospital was not able to move forward with the desired project and in 1992; the hospital completed a typical D-B-B project and had a difficult experience. The hospital has been attracted to the GC/CM model in close collaboration with the Scherer team over the last several years, which has led to the development of a strong team. The hospital believes a GC/CM will provide value.

Mark Scoccolo acknowledged the team's use of AIA documents and questioned whether any consideration was provided for utilizing consensus documentation because of the culture of teamwork the team is attempting to develop. Secondly, he asked if the team will prequalify subcontractors. Mr. Rae said in terms of contracts, the team will be working with Rob Johnson and Perkins and Coie and the team believes the contract that will be

utilized is the best contract for the project. As far as an integrated delivery project, this project is likely not the right project because of the status of design and programming. For that process to be effective, it needs to be implemented at the start of the project.

Rob Johnson pointed out that the AIA contract is heavily modified for this type of project delivery. Mr. Scoccolo commented that the consensus document is available and already tailored for the GC/CM method.

Mr. Rae responded to the question on subcontractor prequalification and noted the team will work with the general contractor to develop subcontractor bid packages. It will be the hospital's responsibility to ensure the hospital is receiving the best value within the subcontractor market and that a sufficient number of subcontractors will bid on the project. When it makes sense for patient safety, for example, each subcontractor package will be evaluated for risk. Mr. Chandler said one expectation of the GC/CM is solid outreach to the trade community. It's important for local contractors to have the opportunity to bid. Another expectation of the GC/CM is educating the submarket to let them know if there are pre-qualifications. The goal is not to exclude anyone, but to solicit as much participation as possible.

Panel Chair Balbo welcomed public comments.

Tony Benjamin, Urban League of Metropolitan Seattle & member of PRC, encouraged the hospital to consider minority and women-owned businesses within the packaging and qualifications process.

Dave Marberg encouraged the team to carefully consider the construction contingency as opposed to construction cost to determine if the contingency in this market is adequate.

Panel Chair Balbo invited panel deliberations.

Mr. Lovell said he supports the project and the use of GC/CM. He offered several recommendations and comments. One concern is the experience on the team to control various user groups and departments after design is underway and the various needs and desires of the departments that likely will be advocated. He urged a level of authority to ensure those issues don't impact the project and organization of the project. When users begin inserting themselves independent of the process there can be problems. Given the size and complexity of the job and the relative newness of the total team, as well as following the new 39.10 process, he urged consideration of using a partnership or team work function with a facilitator coupled with a DRB function with at least one to three members to aid the team.

Mr. Schreiber said his question regarding the proposal was the element of the project that did not appear to be as integrated into the hospital and there was much less support. As a general rule he said he doesn't want the committee to default to GC/CM on projects that could feasibility be completed by D-B-B. The integration of chillers and other elements convinced him beyond the proposal submission that the project is more integrated than it would graphically appear. Attempting to avoid a negative experience of a previous D-B-B project is not necessarily a solid reason for pursuing GC/CM. He said he appreciates the fact that outside of the one question, the package was put together well and based on the response he will support the project for GC/CM.

Ms. Koal expressed support of the project application and commended hospital administration and Commissioner for attending. Hospital staff attending GC/CM training reflects a dedication and respect for the seriousness of the process.

Mr. Pease said the project merits the use of GC/CM. and with the addition of the consultants there is sufficient GC/CM experience.

Mr. Peterson supported the project for GC/CM.

Mr. Scoccolo offered a recommendation of not shortchanging the team in the amount of support that can be included within the process and evaluate resource needs throughout the process. Perhaps some contingency should be included for the team in case additional help is warranted.

Penny Koal moved, seconded by Darren Pease, to approve Mason General Hospital's project application for GC/CM. Motion carried.

The meeting was recessed for a break from 11:50 a.m. to 12:01 p.m.

PRC Chair Lovell invited comments on the panels.

Roger Benson said over the last three years members have learned through the process. The panel did a very good job. However, the fundamental reason for the PRC is to determine if a project is appropriate for alternative delivery and that the team in place is competent to successfully manage the project. Because there is so much expertise represented on the committee, there's a tendency to veer off track and start offering advice on many aspects of the project. It's acceptable to offer advice as part of the comments; however, the committee should avoid comments that are not pertinent to the role and responsibility of the PRC. Because the PRC is a review panel, members ask questions to determine whether the project meets criteria. There appeared to be few questions about criteria with much commentary. It's important to ask questions to determine the competency of the team, but at some point some of the questions can become to overreaching. The commentary can be appropriate but not during the exchange of questions and answers.

Mr. Marberg acknowledged that he offered some advice because he's involved in a hospital project and knows that there are very experienced people who sometimes don't know what to consider. One mistake can be very expensive.

Mr. Benson added that the deliberation by the panel was very little with more focus on the continuation of the discussion with the applicant.

Members exchanged opinions and comments about the process during the question and answer segment and the panel's deliberation. Some members conveyed that the presentation often provides additional information and addresses some of the questions. It was acknowledged that because the PRC is an open public meeting, deliberations of the panel are open. However, if the panel begins asking the applicants questions during the deliberation, it opens the door for the applicants to provide additional presentation and perhaps influencing the panel.

Discussion followed on projects approved that have been completed. Members inquired about data collection on completed projects. Robyn Hofstad advised that staff is collecting and compiling data. Three owners are due for recertification and all data needs to be completed on those owners. Ms. Koal asked whether it's appropriate for PRC to notify owners of the need for recertification. Ms. Hofstad advised that Nancy Deakins notifies the agencies.

Ms. Hofstad addressed questions on the status of data collection. Ms. Riley-Hall noted the City of Seattle encountered problems with the database. The City had to work with GA on the issue involving the submission of information. Additionally, change in staff has also led to delays. Ms. Hofstad advised members if they

initially submit information and log off, after 10 days the system will lock the user. She asked members to contact her if they encounter problems.

Chair Lovell offered that project proponents are becoming smarter in developing the project proposals. However, for those owners that have never undertaken a GC/CM project or the project is substantially greater than previous projects, it's not necessarily ill advised for the PRC to offer suggestions and ideas to assist them. Mr. Benson suggested it would be more appropriate to offer those comments during the comment period and not during the question and answer period.

Ms. Riley-Hall asked about the recertification process in terms of the new legislation and whether the PRC will review the new legislation. Chair Lovell said the legislation is essentially the same criteria but more attuned to the ability and capacity of the institution or the agency to manage the process as opposed to a specific project team. Recertification requires a quorum of the full committee.

Chair Lovell reviewed the agenda of the May 27 meeting of the full PRC. A meeting quorum of 20 members is required. Election of Vice Chair is scheduled on the agenda as well as a briefing by GA staff on the outcome of the legislative session.

Mr. Marberg recommended obtaining an attendance commitment from the members.

Mr. Benson asked about the requirement for the PRC to meet anytime an applicant needs a project review. Chair Lovell said the issue was addressed at a CPARB meeting. Currently, the meeting schedule meets the 60-day requirement. The PRC can, if requested by an owner, schedule an off-month meeting.

It was conveyed that the appropriate response to inquiries regarding scheduling of PRC panel reviews should align with the bi-monthly schedule unless there is a critical need for the panel to meet, in which case the Chair makes the decision to schedule an extra meeting.

Adjournment

Chair Lovell adjourned the meeting at 12:25 p.m.